

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OTC 11/1/12

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER DONELSON PLACE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 203 SS=D	<p>Complaint investigation #28609, #28732, #28881, #28919, and #28933, were completed at Donelson Place Care & Rehabilitation Center on November 14 - 17, 2011. Deficiencies were cited on complaint investigation #28732 and #28919. No deficiencies were cited for complaint investigation #28609, #28881, and #28933, under 42 CFR Part 483, Requirements for Long Term Care Facilities</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this</p>	F 203	<p>F203</p> <ol style="list-style-type: none"> 1. Resident #3 has been discharged home with 24-hour family support and per Adult Protective Service is doing fine. 2. Residents who received involuntary discharge notices would be affected by the deficient practice and there are none currently in the facility. 3. Administrative Staff including (Administrator, DON, ADON, Business Office Manager, Social Services) was in-serviced twice on 11/30/2011 by the administrator. Subject matter included the requirements for proper discharge including regulatory guidance included in F-203 for proper involuntary discharge procedures. To increase their knowledge, the administrator and SSD will attend a seminar on Improper Discharges on 12/01/2011. 	11/30/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Peter E. Hays

Administrator

11/29/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NOV 30 2011

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F 203	<p>Continued From page 1 section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of a facility Involuntary Discharge Notice, review of facility policy, and interview, the facility failed to provide accurate information in a Discharge Notice for one resident (#3) of six residents reviewed.</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on July 15, 2010, with diagnoses including Hemiplegia, Aphasia, Morbid Obesity, and Hypertension.</p>	F 203	<p>4. The administrator will review each Involuntary Discharge Letter to ensure it is compliant with all state and federal guidelines prior to mailing and results of the audits will be forwarded quarterly to the QA Committee for review and recommendations.</p>		

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F 203	Continued From page 2 Review of an Involuntary Discharge Notice, written and issued by the facility, dated September 28, 2011, revealed no documentation of the location to which the resident would be discharged to. Continued review revealed the name, address, and telephone number of the State longterm care ombudsman was incorrect. Review of facility policy "Admission/Transfer/Discharge Notice" dated June 2007, revealed, "...Contents of the notice...The written notice specified in paragraph (a)(4) of this section will include the following: (iii) The location to which the resident is transferred or discharged...(v) The name, address and telephone number of the State long-term care ombudsman..." Interview with the Administrator on November 15, 2011, at 4:00 p.m., in the Conference Room, with the Administrator confirmed the facility failed to provide accurate information in the written Involuntary Discharge Notice.	F 203			
F 221 SS=D	C/O #28919 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility	F 221	F221 1. Resident #4 no longer resides in the facility 2. Any/all residents have the potential for being impacted by this deficient practice. 3. All residents were audited to ensure compliance with guidelines for restraint usage to include the following, pre-assessment, M.D. orders for type of restraint to be		11/30/2011

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F 221	<p>Continued From page 3</p> <p>investigation, review of facility records, and interview, the facility failed to ensure a restraint assessment was completed, an appropriate restraint was used, and a restraint consent was obtained for one (#4) resident of six residents reviewed.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on January 27, 2009, and readmitted on September 9, 2011, with diagnoses including Schizophrenia, Paranoid Personality, Psychosis, Altered Mental Status, Senile Delusions, Senile Depressive, Alzheimer's Disease, General Anxiety Disorder, Dementia with Behavioral Disturbances, Hypertension, Kyphosis, Scoliosis, Osteoarthritis, and Difficulty Walking.</p> <p>Medical record review of a Nurse's Note dated September 14, 2011, revealed "... (12:00 p.m.) agitated, screaming out, trying to get out of wheelchair...taken to dining room for activities... (2:00 p.m.) Ativan given...(5:00 p.m.) put to bed, quietly resting..." Continued review of the Nurse's Notes revealed the resident had ongoing periods of agitation and required Ativan (with less effectiveness each day). Continued review revealed therapy began working with the resident to explore alternative seating (Merriwalker).</p> <p>Review of a facility investigation dated September 14, 2011, at 9:00 p.m., revealed the resident was trying to get out of the wheelchair and the nurse (RN #1) tied a sheet around the resident to prevent the resident from standing and falling out of the wheelchair. A Certified Nurse Assistant (CNA) reported the incident to another nurse (RN</p>	F 221	<p>applied and signed consents. In-services were conducted by the ADON on 09/23/11 on policies and procedures for Restraint Utilization and Residents rights including regulatory guidance F-221. RN#1 was suspended pending investigation and subsequently terminated per the results of the investigation.</p> <p>4. All restraints will be reviewed during the weekly at risk meeting to ensure compliance with policies, regulations and documentation. All restraints will be reviewed during the facility monthly Q/A meetings to ensure compliance with state and federal guidelines related to restraints. Also, random audits will be conducted by the DON and ADON for proper restraint utilization and compliance with regulations. This will include resident observations twice weekly on all shifts for two weeks, weekly for four weeks, then monthly</p>		

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F 221	<p>Continued From page 4</p> <p>#2); RN #2 untied the sheet and instructed RN #1 a sheet is not an appropriate restraint. RN #1 restrained the resident again with a sheet; RN #2 removed the sheet and assigned a CNA to put the resident to bed and provide one-on-one supervision until the resident was calm. Continued review revealed RN #1 was suspended pending investigation. The resident was assessed and was documented as having no injuries secondary to being restrained using a sheet. Continued review revealed the Physician and spouse were notified of the incident and on conclusion of the investigation, RN #1 was terminated for violation of facility policy regarding resident care.</p> <p>Review of the RN #1's personnel record revealed all screenings for abuse and employee hire policies (background check, Office of Inspector General (OIG) exclusion list, abuse registry, reference checks, and drug test) had been completed upon hire (July 13, 2011) and were without negative findings.</p> <p>Medical record review of a Nurse's Note dated September 28, 2011, revealed agitation and behaviors continued to escalate and the resident required one-on-one supervision to prevent injury to self and others, in addition to the psychotropic treatment regimen and behavioral management plan. Continued review on September 28, 2011, revealed psychotropic medications were adjusted, changing the Ativan (1 milligram) from as needed (PRN) to 0.5 milligrams twice daily, routinely. Further review of the Nurse's Notes dated September 29, 2011, revealed adjustment of the medication was not successful; a therapist working with the resident who conducted a trial</p>	F 221	<p>thereafter. Results of audits will be forwarded quarterly to the QA Committee for review and recommendations.</p>		

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F 221	<p>Continued From page 5</p> <p>attempt using a lap buddy was injured by the resident's physical aggression (twisted and bent finger of therapist). The resident became unmanageable, even with one-on-one care, and was at increased risk of harm to self and others. The physician and spouse were notified; at approximately 8:30 p.m., on September 29, 2011, the resident was a direct admission for in-patient care and management to an acute psychiatric hospital. Medical record review revealed the resident was not readmitted to the nursing home due to the facility was unable to provide the care and services required by the resident.</p> <p>Medical record review revealed no documentation of a restraint assessment or restraint consent for the use of a restraint on September 14, 2011.</p> <p>Interview by telephone with RN #1 on November 16, 2011, at 12:06 p.m., confirmed RN #1 restrained the resident using a sheet, a restraint assessment and/or consent was not obtained, and the use of the sheet was inappropriate for a restraint. RN #1 stated "The resident had become so hard to manage...I was trying to keep the resident safe and was so afraid she was going to get up and fall."</p> <p>C/O #28732</p>	F 221			

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